Exhibit A

IN THE CIRCUIT COURT OF

THE SEVENTEENTH JUDICIAL CIRCUIT, IN

AND FOR BROWARD COUNTY, FLORIDA

CLARE AUSTIN,	)	Case No.
Plaintiff,	)	CACE-15-008373
v.	)	
C.R. BARD, INC., a foreign	)	
corporation and BARD	)	
PERIPHERAL VASCULAR, INC.,	)	
an Arizona corporation,	)	
Defendants.	)	

Do Not Disclose – Subject to Further Confidentiality Review

VIDEOTAPED DEPOSITION OF KRISHNA KANDARPA, M.D.

BETHESDA, MARYLAND

THURSDAY, JULY 19, 2018

12:57 P.M.

Pages: 1 - 237

Reported by: Leslie A. Todd

A Correct. Yes, I am.

Q And what does that mean in the context of an IVC filter?

A Okay. That is -- you've got to get this filter that's obviously much larger than the vessel you're trying to put it in through. The femoral vein, for example, may be, depending on the patient and the hydration status, may be somewhere around 8 to 10 millimeters. So you usually use a needle to enter the vein, and then you put a sheath which will carry your collapsed filter. Then you introduce your sheath to the point where you think the filter will land. So once you do that, you pull back on the sheath, and the filter will open its legs and the cone will sit where it's supposed. That is called a deployment. Now you've deployed that filter where you want it.

Q All right. And as the medical monitor, did you have an expectation that when the G2 filter was deployed as part of this study that it would be centered within the vena cava?

MR. NORTH: Objection to the form.

THE WITNESS: That's the expectation.

BY MR. JOHNSON:

Q Yes.

A That's the expectation, absolutely.

Q Did you have an expectation that when the G2 filter was deployed during the study that it would remain in place, remain stable?

MR. NORTH: Objection to the form.

THE WITNESS: That -- that's what -- usually what we want out of any filter, because it's predictability. You know, we don't -- we don't want the filter moving away to the lungs and things like that.

BY MR. JOHNSON:

Q Okay. What about moving downward?

A Well, we don't want it to move at all actually. I think one of the things about these structures you put in is the stability and the -- I can go home and sleep at night thinking it's not going anywhere, you know.

Q All right. Now, you mentioned just a second ago something about the hydration of the patient relating to the inferior vena cava.

A Right.

Q Explain what you meant by that.

it in the right spot, the renal veins will slowly dissolve them. You know, blood from the renal veins will slowly dissolve them.

So that's -- that's what I mean by clot trapping. I mean they are made to trap clots, especially the big ones.

Q All right. And are you familiar with the term "filter migration"?

A Yeah.

Q All right. And what does that mean in the context of an IVC filter?

A Well, it -- it could mean -- it means that the filter has moved from the original spot you -- you put it in. It -- I suppose you could -- you say, I intended to put it here, but it went and sat somewhere else. So that would be filter migration.

Q All right. And I think you mentioned this a second ago, but you talked about strength and stability of the filter as it relates to migration of the filter. Explain what you meant by that.

A Okay. What I meant was the understanding that the structure of the filter

once deployed is now -- is integral to where it's lying so that it's strong enough to stay there and -- and nothing happens to it. So -- so the design of the filter is important in its ability to be stable at a location.

Q Right. I'm going to put Exhibit 3 back up on the ELMO.

A Okay.

Q And hopefully -- let me see if we turn this light off if that helps.

A Is it 3 or 4?

Q I'm sorry, 3.

A Three -- is it 3? Okay.

Q I'm sorry. I don't know if that is any better or not.

In any event, does this illustration show an IVC filter properly in place and centered within the vena cava?

A I would say that it's acceptable. As I said again, it looks like it's a retrieval. It's got a hook. I would like to see it a little higher because -- because -- but, yeah, I mean it's acceptable, it will do its job, but it's not optimal.

of the filters can go right through the heart because the right atrium, the wall is very thin. I've seen this happen, and it's not a good thing to have a hole in your heart.

Q All right. You also mentioned something about the filter moving downward or in a cephalic direction.

A Mm-hmm. A caudal.

Q Caudal.

A It's downward.

Q Oh, I'm sorry. Why do you not want that to happen?

A Well, because it reflects instability. Yeah, I mean, it -- you know, it sort of saying, Well, look, you don't want it moving down. And the other thing is very seldom do we want it moving into the iliac veins because that means the legs are crushed down much further than they would be in the IVC. There are times when you put it there because you don't have a choice, but you wouldn't -- you wouldn't want your filter that you put in the IVC to move into the iliac veins.

Q All right.

A Or any further down, yeah.

Or any further down from where it was, yeah.

BY MR. JOHNSON:

Q All right. Filter tilt, what does that mean?

MR. NORTH: Objection to the form. Seeks expert opinion.

BY MR. JOHNSON:

Q Doctor, as part of your role in this case as the medical monitor, were you evaluating this filter as it relates to tilt?

A Yes, I was.

Q Okay. What does "filter tilt" mean?

A Okay. Well, the implications of filter tilt, if you look at a filter that's deployed properly and you look at it head on within the interior vena cava, you know, a cross-section if you will, you will see that a certain -- there is a certain area that is restricting the clots. What happens when the filter tilts is that those areas increase -- I mean there are studies on this -- and so larger clots can go through.

And in its extreme, it could -- it's not doing -- it's not functioning at all, and --

the things obviously that we look for and made sure that there wasn't an undue amount of that.

BY MR. JOHNSON:

Q Did you form a belief as the medical monitor that there was an association between filter migration, filter tilt, and perforation of the filter through the vena cava?

MR. NORTH: Objection to the form.

THE WITNESS: I didn't form -- I didn't form that opinion because of the study. It's something that happens that's generally known that you don't want that because these are the consequences of a migrating filter. Okay. So I -- I consciously probably didn't say it, but I sort of understood that that was what was going on.

BY MR. JOHNSON:

Q Okay. Did you -- are you saying you understood that was going on with the G2 filter?

A Yes.

MR. NORTH: Objection to the form.

THE WITNESS: In the study, yes.

BY MR. JOHNSON:

Q Okay. This retrievability study, was it

perforation of the filter through the inferior vena cava?

A Yes.

MR. NORTH: Objection to the form.

THE WITNESS: Yes.

BY MR. JOHNSON:

Q All right. I'm not going to continue going through this document.

A Okay.

Q But based on your work as the medical monitor in this case, based upon your device observations and adverse events that you were responsible to adjudicate, did you form a belief that there was a stability problem with the G2 filter?

MR. NORTH: Objection to the form.

THE WITNESS: Yeah. Yes, I think when you look at the totality of all the findings and you try to relate them, that you -- you would think that it stems primarily from the stability of filter position once deployed.

MR. JOHNSON: Okay. What's our next exhibit? I don't want to make -- continue making a mistake.

Q What -- what does the migration rate that you were aware of as the medical monitor indicate to you regarding the strength and stability of the G2 filter?

MR. NORTH: Objection to the form.

THE WITNESS: I -- I could tell you that -- that it -- that it's suffering from an ability to be placed stably. Once you lose that ability, you can move and you can be positioned in ways with the inferior vena cava where you're subjected to forces, you know, like the pulsations and everything else, that struts might not have been designed for, so you're then predisposed to fatigue fractures and all the rest of it. So it's not something that I would take lightly.

BY MR. JOHNSON:

Q All right. As the medical monitor, did you form a belief that the migration rate that you observed was high?

A Yes.

MR. NORTH: Objection to the form.

BY MR. JOHNSON:

Q What -- what that was belief?

A I believed that the migration rate was

higher than -- than in my experience.

Q Were there definite cranial migrations or upwards migrations of the G2 filter that you observed as the medical monitor?

MR. NORTH: Objection to the form.

THE WITNESS: I cannot remember individual ones, but clearly it's recorded and I must have seen them.

BY MR. JOHNSON:

Q Do you have a recollection of there being upward or cranial migrations of the G2 filter that were observed by you?

A Yeah, probably. Yeah -- I mean as I said again, I mean I can't remember individual ones, especially the one that says 5 millimeters upward cranial, you know, I mean I remember that, but anything that's big in terms of anything more than 1 centimeter, you know, that would be something that we would have talked about.

Q Go ahead.

A No. Yeah -- so, yeah, obviously I saw it. I don't -- given 12 years, I don't remember individual cases.

Q With respect to the migration rate that

looks like it might could use a redesign.

Q All right.

A Yeah.

Q Looking back on the device observations, looking back on the adverse events, you've made it clear that it was not within your power to either stop this study or to initiate a process to stop this study.

A Mm-hmm.

Q If you had that ability, would you have done so?

MR. NORTH: Objection to the form.

THE WITNESS: Yes. Yeah. If I had the ability, and I was told, you know, you are responsible for letting people know about these issues, other than through the channels through BBA, yeah -- and if I had responsibility for that, definitely. Yeah.

BY MR. JOHNSON:

Q Doctor, you've spoken to us about caudal migration, and that is downward migration, as well as upward migration, and I believe we've established that you were involved in this adverse event adjudication and device observation

Q Yes.
A Yeah, it would be. Yeah.
Q And when a IVC filter is being represented as having improved centering, what does that mean to you?
A I just -- that means that when I'm deploying it, that chances are high that it will stay with the cone in the middle of the lumen. That's what it -- that's what the message is, improved centering. That it's not going to tilt, it's not going to -- it's going to stay there where I want it to be with the maximum filtration faced towards the flow.
Q Was that something that you experienced -- was that the case with the G2 filter in the EVEREST Study, that it had improved centering over other devices on the market?
A Well, not when -- well, you can't conclude that. You can't conclude that given -- given the fact that there were so many tilts and migrations.
Q Now, did you know, Doctor, that in June of 2006 when you were involved in the study, that Bard also met with some of your colleagues and had

CERTIFICATE OF CERTIFIED SHORTHAND REPORTER

The undersigned Certified Shorthand Reporter does hereby certify:

That the foregoing proceeding was taken before me at the time and place therein set forth, at which time the witness was duly sworn; That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed, said transcript being a true and correct copy of my shorthand notes thereof; That the dismantling of the original transcript will void the reporter's certificate.

In witness thereof, I have subscribed my name this date: 24th day of July 2018.

_____

LESLIE A. TODD, CSR, RPR

Certificate No. 5129

(The foregoing certification of this transcript does not apply to any reproduction of the same by any means, unless under the direct control and/or supervision of the certifying reporter.)